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This Booklet is for Limited Distribution Only

Federal Employees Health Benefits Program

ATTENTION AETNA ENROLLEES
Aetna's **Government-wide Indemnity Benefit Plan** will not be in the FEHB Program in 1990. Read the important notice on **page 2** about filing a new enrollment.

1990 Enrollment Information Guide and Plan Comparison Chart

1989 Open Season

For Federal Civilian Employees in Positions Outside the Continental U.S. (including States of Alaska and Hawaii, and Islands of Guam and Puerto Rico)

This booklet contains information about enrollment in the Federal Employees Health Benefits Program during the Open Season that begins on November 13 and continues through December 8, 1989. It will help you select the health care protection best suited to your needs. However, before you make a final choice, you should review carefully the official brochures for those plans in which you are interested. While this booklet provides a general overview of the health benefits offered by each plan, the official brochures provide the contractual description of coverage.

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NOTICE TO AETNA ENROLLEES

The **Government-wide Indemnity Benefit Plan** (Enrollment Codes 201, 202, 204, and 205) administered by Aetna will not be in the FEHB Program in 1990. In order to continue participating in the FEHB Program, you **must** file a change of enrollment with your employing office, using Standard Form (SF) 2809. Failure to enroll in another FEHB plan during the Open Season will be considered a voluntary cancellation of your participation in the FEHB Program.

Introduction

The Federal Employees Health Benefits Program offers you a practical way to help meet the costs of health care. The Program provides:

- a choice of plans and options;
- a Government contribution toward the cost of your premium;
- payments for your share of the premium through payroll deductions;
- immediate coverage from the date of enrollment without a medical examination or restrictions because of your age or physical condition;
- under certain circumstances, opportunity for temporary continuation of group coverage or conversion to nongroup coverage if you enrollment ends or a covered family member loses eligibility for coverage.
- if certain conditions are met, continued protection for you and eligible family members after your retirement and for eligible family members after your death.

About Open Season

Each year the Office of Personnel Management reviews the benefits and premiums of the plans in the Federal Employees Health Benefits Program and negotiates adjustments in benefits and premiums to be effective the following January. Also, some new plans are accepted for participation in the Program and some plans cease to participate.

Open Season is your annual opportunity to join the Federal Employees Health Benefits Program if you are not already enrolled. If you are enrolled, it is your opportunity to change your health plan coverage to become effective the following January.

If you are enrolled and do not wish to make a change, your current enrollment will continue without any additional action on your part. **However, you should check the Comparison Chart in this booklet to be sure that the plan and option you are currently enrolled in will be participating in the Federal Employees Health Benefits Program in 1990.**

If you want to enroll in the Federal Employees Health Benefits Program or change your current health plan enrollment during Open Season, you must file a Health Benefits Registration Form (Standard Form [SF] 2809) in time for it to be received by your employing office by December 8, 1989. Your employing office can give you the specific day in January 1990 on which your enrollment change will take effect.

Making Your Choice

The Federal Employees Health Benefits Program includes a variety of health benefits plans that take very different approaches to health care coverage.

You may choose one of the traditional fee-for-service health benefits plans. In these plans, you are free to go to virtually any doctor or hospital of your choice and have the provider either bill the plan directly or give you the bill to forward to the plan for payment of covered services. Or, if you live in Guam, Hawaii or Puerto Rico, you may choose one of the prepaid comprehensive medical plans that operate through a group of affiliated doctors and hospitals. In these plans, most of your covered services are prepaid by your premium and are available only from the affiliated providers.

In deciding which type of plan best meets your needs, you might consider the following:

- the coverage offered by each type of plan;
- the cost of each plan; and
- the accessibility of health care services.

Before you make a final decision, be sure to review the official brochures for those plans in which you are interested.

The Cost of Coverage

You and the Government share the cost of your premiums.

The Government normally pays 60 percent of the average high option premium of six of the largest health benefits plans in the Federal Employees Health Benefits Program but not more than 75 percent of the premium for any individual plan (for Postal employees the Government pays a higher share). However, this formula has been modified for 1990 (and 1991) because of the departure from the Program of the Aetna Plan, whose high option premium previously had been used in computing the Government's share. For 1990, the maximum biweekly Government contribution is $52.33 for a self only enrollment and $112.54 for a family enrollment. The maximum monthly Government contribution is $113.38 for self only and $243.84 for family.

You must pay the remainder of premium costs. The premium costs on the Comparison Chart in this booklet show your share only -- the amount you must pay, which will be withheld from your salary. (If you are not a full-time employee, your share of the premium may be different. Your employing office can tell you the specific amount.)

When comparing plans, remember that the true cost of your health care protection includes both the premiums and your out-of-pocket costs for any deductibles, coinsurance, copayments, examinations and other physician services, laboratory tests, prescription drugs, etc.

Another factor to keep in mind when comparing plans, especially fee-for-service plans, is the extent to which benefit payments are based on reasonable and customary charges. Please refer to the definitions in this booklet for an explanation of this factor and then see the brochures for the plans in which you are interested.

Who Is Covered Under Your Enrollment

- **Self only enrollment** -- A self only enrollment provides benefits just for you -- the enrolled employee.

- **Self and family enrollment** -- A self and family enrollment provides benefits for you, your spouse, and your unmarried dependent children under 22 years old. In some cases, a disabled child who is 22 years old or older is eligible for coverage if you have adequate medical certification of a mental or physical handicap that existed before his or her 22nd birthday. In such cases, you should ask your employing office about the documentation required.

  Children covered by your enrollment include your legally adopted children, recognized children born out of wedlock, and stepchildren or foster children, if they live with you in a regular parent-child relationship and you meet certain other requirements. Ask your employing office for details about these requirements. Children whose marriage ends before they reach age 22 become eligible for coverage from the date the marriage ends until they reach age 22.

  Other relatives -- your parents, for example -- are not eligible for coverage even though they live with you and are dependent upon you.

  To provide coverage for a new eligible family member, you must elect, or change to, a self and family enrollment.

Types of Federal Employees Health Benefits Plans Available

Two basic types of health benefits plans are available to you under the Federal Employees Health Benefits Program:

Fee-for-Service Plans -- These plans reimburse you or the health care provider for covered services. If you enroll in one of these plans, you may choose your own physician, hospital, and other health care providers.

Fee-for-service plans include the Blue Cross and Blue Shield Service Benefit Plan and plans sponsored by unions and other employee organizations. All fee-for-service plans pay for covered services rendered outside the continental United States.

The Service Benefit Plan is open to all Federal employees. Some employee organization plans are open to all Federal employees through full or associate memberships in the organizations that sponsor the plans; other employee organization plans are restricted to employees in certain occupational groups and/or agencies. (See the union and other employee organization plan brochures for information about membership and membership fees, which are **in addition** to your biweekly or monthly premiums. These membership fees are **not** part of the Federal Employees Health Benefits Program.)

Prepaid Plans -- These are the Comprehensive Medical Plans/Health Maintenance Organizations (CMP/HMOs) that provide or arrange for health care by **designated** plan physicians, hospitals, and other providers in particular locations. CMP/HMOs pay all providers through salaries or other payment arrangements. You pay any required cost-sharing amounts.

Comprehensive Medical Plans/Health Maintenance Organizations are either Group Practice Plans, Individual Practice Plans or a combination of both (called Mixed Model Plans). Group Practice Plans provide care through staff physicians practicing at one or more medical centers operated by the plans. Individual Practice Plans provide care through participating plan physicians practicing in their own offices. The plans arrange hospital and other care not available in centers and offices when necessary.

Each CMP/HMO is open to all Federal employees who live within the plan's enrollment area. If you live in Guam, Hawaii, or Puerto Rico, you may enroll in a CMP/HMO.

General Information About Enrollment and Coverage

Dual Enrollment
Normally, you may not enroll or be enrolled as an employee if you are covered as a family member under someone else's enrollment in the Federal Employees Health Benefits Program. However, such dual enrollments may be permitted under certain circumstances in order to:

- Protect the interests of children who otherwise would lose coverage as family members, or
- Enable an employee who is under age 22 and covered under a parent's enrollment and becomes the parent of a child to enroll for self and family coverage.

No person (employee or family member) is entitled to receive benefits under more than one enrollment in the Program.

Continuation of Enrollment After Retirement
To continue your enrollment after you retire, you must retire:

- Under a retirement system specifically for Federal civilian employees, and
- On an immediate annuity.

In addition, you must be currently enrolled in a plan under the Federal Employees Health Benefits Program and must have been enrolled (or covered as a family member) in a plan under the Program for:

- The five years of service **immediately** before retirement, or
- If fewer than five years, **all** service since your **first** opportunity to enroll. (Generally, your first opportunity to enroll is within 31 days after your first appointment [in your Federal career] to a position under which you are eligible to enroll under conditions that permit a Government contribution toward the enrollment.)

Temporary Continuation of Coverage

If your enrollment is terminated because you separate from service on or after January 1, 1990, you may be eligible to temporarily continue your health benefits coverage under the Federal Employees Health Benefits Program after separation. Temporary continuation of coverage is available to you if your separation is voluntary or involuntary (unless it is for gross misconduct), and you would not otherwise be eligible for continued coverage under the Program. Included is separation for retirement when you are unable to meet the five-year enrollment requirement for continuation of enrollment after retirement (see page 5).

Your temporary coverage would continue for up to 18 months after your separation from service, and you would pay the total premium (both the employee and Government contributions) plus a charge for administrative expenses of 2% of the total premium. When your temporary continuation of coverage ended (except by cancellation or nonpayment of premiums), you would be entitled to a 31-day extension of coverage and an opportunity to convert to a nongroup health benefits contract.

In certain cases, a covered child who loses eligibility for coverage and a former spouse who is not eligible to enroll in the Federal Employees Health Benefits Program under the Spouse Equity law or similar statutes, on or after January 1, 1990, also may qualify for temporary continuation of coverage. Their temporary coverage would continue for up to 36 months after the qualifying event occurs, and they also would pay the total premium plus the 2% administrative charge. In addition, child and former spouse enrollees would be entitled to a 31-day extension of coverage and an opportunity to convert to a nongroup health benefits contract when their temporary continuation of coverage ended (except by cancellation or nonpayment of premiums).

Your employing office will notify you of your opportunity to elect temporary continuation of coverage within 61 days after your enrollment terminates because of separation from service. You will have 60 days after receiving the notice (or after separation, if later) to elect continued coverage. However, the employing office must be notified in the case of children or former spouses who are eligible to temporarily continue coverage. For a child, the enrollee must notify the employing office within 60 days after the qualifying event occurs. For a former spouse, the employee or the former spouse must notify the employing office within 60 days after the marriage ends. The employing office then will notify the child or the former spouse of his or her temporary continuation of coverage rights. If a child wants continued coverage, he or she must elect it within 60 days after receiving the notice (or after the date of the qualifying event, if later). If a former spouse wants continued coverage, he or she must make the election within 60 days after the later of :

- The date he or she receives the notice;
- The date of the qualifying event; or
- The date he or she loses coverage as an enrolled former spouse because of remarriage or loss of qualifying court order.

Important: If the employing office is not notified that a child or former spouse has lost coverage, the opportunity to elect continued coverage on a temporary basis ends 60 days after the event which caused the loss of coverage.

Cancellation of Enrollment

You may voluntarily cancel your enrollment at any time. However, once your cancellation takes effect, you may not enroll again until an event occurs that permits enrollment, *e.g.*, change in marital status or the next Open Season. In addition, you will not be eligible to continue your enrollment after you retire unless you reenroll before you retire and meet all the requirements for continuation of enrollment after retirement, including the five-year enrollment requirement (see pages 5 and 9).

Your employing office can give you details about the above enrollment and coverage information.

Definitions

Insurance is a fairly complex subject and the technical terms and details about benefits may be difficult to understand. The following terms, which have special meaning in the health care field, have been defined, as much as possible, in everyday English to help you understand the benefits coverage and limitations of the various plans in the Federal Employees Health Benefits Program:

Brochure -- the booklet showing the complete details of a plan's benefits, limitations (or limited benefits), exclusions, and definitions. The brochure is a plan's contractual statement of benefits.

Catastrophic Limit -- a feature of fee-for-service plans to limit the amount you would have to pay in a calendar year if you or your family incurred large and unusual medical bills. The catastrophic limit is the maximum amount of **covered** expenses you would have to pay out of your own pocket during the year for yourself and your family. There are separate catastrophic limits for medical-surgical expenses and inpatient care for mental conditions. The limits apply to your coinsurance payments and, depending on the plan, may also include the calendar year, inpatient and mental health deductibles you pay. **Please refer to the brochures for the fee-for-service plans in which you are interested.**

Coinsurance -- the fixed percentage of covered charges **you** must pay after any deductible has been subtracted. For example, if a plan that has a coinsurance feature pays 80 percent of covered charges (after applying any deductible), you would be responsible for the deductible and the 20 percent balance.

Copayment -- a fixed dollar amount you must pay for a service or benefit provided by a plan. For example, some prepaid plans (CMP/HMOs) charge a copayment of $50 or more per hospital admission or $2 or more for a doctor's visit.

Covered Charges -- the amount of your expenses for medical care that is covered by a plan. An expense that is not a covered charge cannot be used to satisfy the plan's deductible. Often a plan includes as covered charges only an amount specified in a scheduled allowance or based on a reasonable and customary profile. See the plan brochures to find out how covered charges are determined.

Covered charges do not include expenses for nonmedical items related to an illness or injury, or for specific items excluded by the plan.

Deductible -- the amount of covered charges you must incur before the plan pays benefits.

Dental Care -- coverage may include routine diagnostic and preventive services and one or more of the following treatment services: restorative, crown and bridge, endodontic, oral surgery, periodontal, prosthetic and orthodontic. Some prepaid plans (CMP/HMOs) limit coverage to preventive services for children. **Please refer to plan brochures for a definition of covered services, exclusions, and limitations.**

Enrollment Area -- the area within which a prepaid plan (CMP/HMO) enrolls members. To be eligible to enroll in a CMP/HMO, you must live within this area. The plan brochure identifies the enrollment area.

Exclusions -- charges, services, or supplies that are not covered. A plan does not provide or pay for excluded items, nor do charges for them apply towards deductibles or catastrophic limits.

Extended Care Facility -- an institution that furnishes, in lieu of hospitalization, room and board and medically prescribed skilled nursing care 24 hours a day by an organized medical staff; and is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics or domiciliary care.

Home Health Care -- medically supervised care and treatment in the home of a patient whose physician certifies that, without such care, confinement in a hospital or extended care facility would be required. Typically, care and treatment are provided in accordance with an approved home health care plan and must begin within a specified period of time after discharge from a hospital.

Home Nursing Care -- skilled care in the home provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), or licensed vocational nurse (L.V.N.). The care generally must be ordered by a physician; is usually limited to a specified number of hours per day and visits per year; and does not include homemaking services of any kind.

Hospice Care -- a coordinated program of home and/or inpatient palliative and supportive care for a terminally ill patient and the patient's family provided by a medically supervised specialized team under the direction of a licensed or certified hospice care facility or agency.

Inpatient Services -- the care provided to you while you are a bedpatient in a covered facility.

Limitations (or Limited Benefits) -- statements in the brochure showing services or supplies that are not fully covered; only partially paid for by a plan; or covered only if the service or supply provided meets certain specified criteria, *e.g.*, pre-admission testing within 72 hours of surgery.

Maternity Care -- prenatal and postnatal care and delivery by a covered hospital, physician, or other covered practitioner, including, in many cases, nurse midwives. The plan brochure will specify coverage for nurse midwives. Plans generally pay for maternity care the same as for other covered inpatient and outpatient services.

Mental Conditions/Substance Abuse -- conditions and diseases listed in the most recent edition of the International Classification of Diseases (ICD) as psychoses, neurotic disorders, and personality disorders; also other non-psychotic mental disorders listed in the ICD, as determined by the plan. **Please refer to plan brochures for a definition of covered services, exclusions, and limitations.**

Outpatient Services -- the care provided to you in the outpatient department of a hospital, in a clinic or other medical facility, or in a doctor's office.

Prescription Drugs -- outpatient drugs and medicines which, by United States law, cannot be obtained without a doctor's prescription.

Reasonable and Customary Charge -- one of two benefit maximums plans use as the amount of your medical or dental care expenses they will cover for a particular service. (The other is the Scheduled Allowance, defined below.) A Reasonable and Customary Charge is the amount a plan considers to be covered based on a profile of charges determined by the plan to be the amount a provider normally charges for a service and that is usually charged by most other providers for the same service in the same geographic area. Health insurance industry-accepted methods are used by the plans to establish and periodically update reasonable and customary charges. You must pay any amount a provider charges above the applicable reasonable and customary charge.

Scheduled Allowance -- one of two benefit maximums plans use as the amount of your medical or dental care expenses they will cover for a particular service. (The other is the Reasonable and Customary Charge, defined above.) A Scheduled Allowance is the fixed dollar amount that has been assigned to a covered medical or dental service. You must pay any amount the provider charges above it. (Because a plan's Scheduled Allowance for a particular service applies nationwide, and the amount a provider charges for that service may vary geographically, the Scheduled Allowance is likely to defray more of the provider's charge in some areas than in others.)

Service Area -- the area where prepaid plan (CMP/HMO) providers and facilities are available to you. This area would be the same as, or within, the plan's enrollment area.

Using the Plan Comparison Chart

The Plan Comparison Chart on the following pages provides general information about many of the major features of each plan in the Federal Employees Health Benefits Program that may be available to you as an employee in a position outside the continental United States, including a position in Alaska, Guam, Hawaii or Puerto Rico. It is a tool to help you reach a basic understanding of the plans in which you may enroll and to assist you in comparing benefits as well as premiums and other items of cost to you. You can compare benefits among plans by reviewing categories of services and other features. You can determine relative cost among plans by comparing your share of the premiums and your out-of-pocket expenses as reflected by deductibles, copayments, coinsurance, and catastrophic limits.

However, **don't rely on the Chart alone.** Detailed information about plan benefits and the contractual description of coverage appear in the plan brochures. All benefits are subject to the definitions, limitations and exclusions set forth in the brochures. **So before you make a final decision, you should review carefully the official brochure for the plan or plans in which you are interested.**

Warning for Employees Considering Declining or Cancelling Enrollment

If you wish to be covered under the FEHB Program when you retire, you are required by law to participate in the Program as either an enrollee or a covered family member for the five years of service immediately before your retirement (or if you have been employed in an eligible position for less than five years when you retire, for all of the time during which you were eligible to enroll under conditions that permit a Government contribution toward the enrollment). The law established this requirement specifically to preclude last minute pre-retirement enrollments in the Program.

Many employees decline or cancel FEHB coverage because they are insured through a spouse or have some other source of benefits outside of the FEHB Program. Unfortunately, some people believe incorrectly that they can enroll in FEHB just before their retirement and that OPM will waive the five-year requirement in their case. In fact, OPM may waive only in **rare** and unusual circumstances.

In order to be eligible for a waiver, you would need to provide convincing evidence which demonstrated that (1) you intended to be covered by an FEHB plan as an annuitant; (2) the circumstances that prevented you from meeting the participation requirement were essentially outside of your control; and (3) you exercised due diligence in protecting your right to coverage as an annuitant.

OPM will not grant a waiver solely because your retirement is based on disability or an involuntary separation, because you were misadvised or not advised by your employing office regarding the participation requirement, or because you would be without insurance.

Now that you have a better understanding of how the five-year requirement works, you may decide whether to enroll or remain enrolled in the FEHB Program. Remember that you have many different plans from which to choose. Please make your decision carefully.

FEHB Plan Comparison Chart - For Benefits Beginning in January 1990

Fee-for-Service Plans

† ATTENTION CURRENT NFFE ENROLLEES:
The NFFE plan has terminated its high option and will become a single option plan in 1990. If you are enrolled in the NFFE **high option** in 1989, you cannot continue your enrollment in that option in 1990; you **must** file a new enrollment with your employing office, using Standard Form (SF) 2809. If you fail to enroll in either NFFE (new plan code YB) or another FEHB plan, regulations require your employing office to change your enrollment to the NFFE plan.

- All plans require you to share costs for covered charges. In addition to the calendar year deductible (see below), other cost-sharing amounts you pay may include coinsurance, copayments and/or inpatient deductibles.
- The calendar year deductible shown is the per person amount. Under a Self and Family enrollment, generally no more than two or three family members, depending on the plan, must meet this deductible. For a few plans, which have established a family deductible, the per person amount shown applies to just one person; the difference between it and the family deductible can be met by any or all of those covered. The calendar year deductible may not apply to every covered charge.
- The amounts of covered charges that plans pay for medical-surgical primary care shown on the next page are maximum amounts. Payments may be affected, however, by certain limitations and conditions, which are described in the plan brochures.

	Plan Name and Option		Enrollment Code			Brochure Number RI	Plan Telephone Number	1990 Monthly Premium Your Share		1990 Biweekly Premium Your Share		Medical-Surgical Primary Care You Pay	
			Plan Code	Self Only	Self & Family			Self Only	Self & Family	Self Only	Self & Family	Calendar Year Deductible	Catastrophic Limit (max. covered out of pocket) person/family
	AFGE	High	30	1	2	71-2	(202) 783-0504	234.07	436.06	108.03	201.26	$200	$1,500/$1,500
		Stnd	30	4	5	71-2	(202) 783-0504	31.08	67.40	14.34	31.11	NA	$2,500‡
	Alliance	High	46	1	2	71-3	(202) 939-6325	163.24	491.66	75.34	226.92	$250	$1,500/$2,500
		Stnd	46	4	5	71-3	(202) 939-6325	33.14	79.93	15.30	36.89	$325	$2,500/$2,500
	APWU		47	1	2	71-4	(301) 622-1700	39.31	80.85	18.14	37.31	$175	$1,750/$1,750
*	BACE		Y2	1	2	72-8	(301) 881-0510	36.38	99.75	16.79	46.04	$150	$1,500/$1,500
	Blue Cross-Blue Shield (Service Benefit)	High	10	1	2	71-5	(202) 484-1660	187.81	391.97	86.68	180.91	$200	$1,500/$1,500
		Stnd	10	4	5	71-5	**	36.66	77.03	16.92	35.55	$250	$2,500/$2,500
*	Foreign Service		40	1	2	72-1	(202) 833-4910	48.60	149.97	22.43	69.22	$175	$1,500/$1,500
*	GEBA		YZ	1	2	72-2	(301) 688-7912	48.80	148.02	22.52	68.32	$250	$2,500/$2,500
	GEHA		31	1	2	71-6	(816) 753-1260	41.52	82.22	19.16	37.95	$250	$2,000/$2,000
	Mail Handlers	High	45	1	2	71-7	(301) 738-1260	30.54	68.07	14.09	31.42	NA	$2,500/$5,000
		Stnd	45	4	5	71-7	(301) 738-1260	24.42	53.03	11.27	24.47	NA	$2,500/$5,000
	NAGE	High	YJ	1	2	71-8	(202) 371-6644	217.43	529.03	100.35	244.17	$200	$1,500/$2,500
		Stnd	YJ	4	5	71-8	(202) 371-6644	42.99	129.20	19.84	59.63	$250	$2,000/$3,000
	NALC		32	1	2	71-9	(703) 471-1550	64.18	109.89	29.62	50.72	$200	$1,000/$3,000
*	NAPUS		YP	1	2	72-3	(703) 683-9027	101.75	209.95	46.96	96.90	$200	$700/$1,400
†	NFFE		YB	1	2	71-10	(301) 738-1216	80.84	212.37	37.31	98.02	$250	$1000/$2,000
	NTEU		YY	1	2	71-11	(202) 785-4411	46.76	117.93	21.58	54.43	$275	$2,250/$2,250
*	Panama Canal Area		43	1	2	72-4	(504) 566-1300	30.98	67.18	14.30	31.01	NA	$1,000‡
	Postal Supervisors		YV	1	2	71-12	(301) 738-1216	88.64	235.06	40.91	108.49	$250	$1,500/$1,500
	Postmasters	High	36	1	2	71-13	(703) 683-5585	130.07	281.40	60.03	129.88	$250	$2,000/$2,500
		Stnd	36	4	5	71-13	(703) 683-5585	34.82	95.74	16.07	44.19	$275	$2,500/$2,500
*	Rural Carriers		38	1	2	72-5	(301) 963-0001	42.40	76.83	19.57	35.46	$250	$1,500/$3,000
*	SAMBA		44	1	2	72-6	(301) 984-1440	49.66	171.16	22.92	79.00	$300	$1,000/$2,000
*	Secret Service		Y7	1	2	72-11	(202) 479-6039	28.48	71.21	13.14	32.86	$200	$1,000/$2,000

* Plans are open ONLY to specific groups

‡ Per person

** If you live in Alaska, Hawaii or Puerto Rico, see your local phone book.

ABBREVIATIONS: ECF — Extended Care Facility
HHC — Home Health Care
NA — Not Applicable
R & C — Reasonable & Customary
SA — Scheduled Allowance

Do Not Rely on This Chart Alone - See Plan Brochures for Details

- Most plans require that accidental injury care must be received within a specified number of hours of the injury for the amounts shown to apply.
- The mental conditions inpatient catastrophic limit is the maximum amount of covered out-of-pocket expenses you pay per person per year until the plan pays up to the lifetime maximum; you pay any expenses that exceed it. The lifetime maximum is the amount up to which plans pay per person for covered mental conditions inpatient services.
- While not shown on the Chart, virtually all of the fee-for-service plans provide:
  —Mental conditions outpatient care benefits, which usually have dollar and/or visit limits, and you share costs to these limits.
  —Inpatient and outpatient care benefits for alcoholism and drug abuse, which usually have dollar, day and/or visit limits, and you share costs to these limits.
  —Inpatient and outpatient hospice care benefits, which have a dollar maximum that varies by plan.
  See plan brochures for details.

Medical - Surgical Primary Care								Mental Conditions		Other Benefit Features			
Plan Pays								Inpatient Care					
Inpatient Care				Outpatient Care									
Hospital Charges		Physician Charges		Physician Charges		Diagnostic Tests (R & C)	Accidental Injury Care (R & C)	You Pay	Plan Pays	ECF and/or HHC	Dental Care	Rx Drugs	Chiro-practor
Room & Board	Other Hosp. Exp.	Surgeons (R & C)	Other Drs (R & C)	Surgeons (R & C)	Other Drs (R & C)			Catastrophic Limit ‡	Lifetime Maximum ‡				
100%	100%	100%	80%	100%	80%	80%	100%	$6,000	$50,000	Both	No	Yes	Yes
100%	80%	SA	SA	SA	SA	SA	SA	$5,000	$25,000	ECF	Yes	Yes	No
100%	100%	80%	80%	100%	80%	80%	100%	$8,000	$50,000	Both	Yes	Yes	Yes
100%	100%	75%	75%	90%	75%	75%	100%	$8,000	$50,000	Both	Yes	Yes	Yes
100%	80%	85%	85%	100%	85%	85%	85%	$8,000	$25,000	HHC	Yes	Yes	No
100%	100%	80%	80%	100%	80%	80%	100%	$8,000	$50,000	Both	Yes	Yes	Yes
100%	100%	80%	80%	80%	80%	80%	100%	$4,000	$75,000	HHC	No	Yes	No
100%	100%	75%	75%	75%	75%	75%	100%	$8,000	$50,000	No	Yes	Yes	No
100%	80%	90%	80%	100%	80%	80%	100%	$1,500	None	Both	Yes	Yes	No
100%	75%	75%	75%	85%	75%	75%	100%	$10,000	$25,000	Both	Yes	Yes	Yes
100%	80%	80%	80%	85%	85%	85%	100%	$8,000	$50,000	HHC	Yes	Yes	Yes
100%	100%	SA	SA	SA	SA	SA	75%	$5,000	$25,000	No	Yes	Yes	Yes
100%	100%	SA	SA	SA	SA	SA	75%	$5,000	$25,000	No	No	Yes	Yes
90%	90%	90%	80%	90%	80%	80%	100%	$7,500	$50,000	Both	Yes	Yes	Yes
75%	75%	75%	75%	75%	75%	75%	75%	$8,000	$50,000	Both	Yes	Yes	Yes
100%	80%	85%	75%	85%	75%	75%	SA	$8,000	$50,000	HHC	Yes	Yes	No
100%	100%	75%	75%	100%	75%	75%	100%	$4,200	$50,000	Both	Yes	Yes	Yes
100%	100%	75%	75%	75%	75%	75%	100%	Variable	$40,000	HHC	Yes	Yes	Yes
100%	100%	75%	75%	100%	75%	75%	100%	None	None	Both	Yes	Yes	Yes
100%	80%	100%	SA	100%	SA	SA	100%	None	None	No	Yes	Yes	Yes
100%	100%	80%	75%	90%	75%	75%	100%	$8,000	$50,000	Both	Yes	Yes	Yes
100%	85%	90%	80%	100%	80%	80%	80%	$8,000	$40,000	Both	Yes	Yes	Yes
100%	80%	SA	75%	SA	75%	75%	75%	$8,000	$40,000	Both	Yes	Yes	Yes
100%	80%	90%	75%	90%	75%	75%	SA	$8,000	None	Both	Yes	Yes	Yes
100%	90%	100%	80%	100%	80%	80%	100%	$6,500	$50,000	Both	No	Yes	Yes
100%	100%	80%	80%	80%	80%	80%	100%	$4,000	$50,000	Both	Yes	Yes	Yes

The above benefits may be subject to dollar, day and/or visit limits; as well as preadmission approval, precertification, second opinion and/or other requirements. Read the plan brochures carefully.

FEHB Plan Comparison Chart - For Benefits Beginning in January 1990

Prepaid Plans (Commonly referred to as CMP/HMOs)

- A plan's general location is the approximate area served by the plan. To enroll in a CMP/HMO, you **MUST** live within the plan's enrollment area. See the plan brochure or call the plan for the exact enrollment area.
- While some CMP/HMOs require you to share costs for certain services, *e.g.*, nominal office visit copayments, most do not require cost sharing for hospital care, surgery and/or diagnostic tests.
- Every CMP/HMO provides physicals and immunizations.
- All CMP/HMO benefit packages include catastrophic coverage, since these plans provide for necessary care during a year.
- Every CMP/HMO provides benefits for mental conditions/substance abuse inpatient and outpatient services. However, benefits are limited to short-term care, generally 30 to 45 days of inpatient care and 20 to 35 outpatient visits per calendar year, depending on the plan. You typically share costs to benefit limits. Although the Comparison Chart doesn't include CMP/HMO mental conditions/substance abuse benefits information, you can find the information in the plan brochures.
- Most CMP/HMOs provide hospice care benefits.

Plan Name and Option	Enrollment Code			Brochure Number RI	General Location	Plan Telephone Number	Plan Type	1990 Monthly Premium Your Share		1990 Biweekly Premium Your Share		Other Benefit Features			
	Plan Code	Self Only	Self & Family					Self Only	Self & Family	Self Only	Self & Family	ECF and/or HHC	Dental Care	Rx Drugs	Chiro-prac-tor
Guam															
FHP/Guam	JK	1	2	73-18	Guam	646-1984	GPP	26.30	77.52	12.14	35.78	Both	Yes	Yes	No
Guam Memorial Health Plan (High)	ZA	1	2	73-213	Guam	(671) 472 4647	IPP	30.83	78.99	14.23	36.46	Both	Yes	Yes	Yes
Guam Memorial Health Plan (Stnd)	ZA	4	5	73-213	Guam	(671) 472-4647	IPP	22.05	58.92	10.18	27.19	Both	No	Yes	Yes
Health Maintenance Life	28	1	2	73-36	Guam	646-7826	IPP	20.43	61.56	9.43	28.41	Both	Yes	Yes	No
Hawaii															
HMSA	87	1	2	73-10	Hawaii	(808) 942-1111	IPP	30.16	79.93	13.92	36.89	Both	Yes	Yes	No
HMSA's Community Health Program	F6	1	2	73-60	Hawaii	(808) 944-2372	GPP	30.92	97.50	14.27	45.00	Both	Yes	Yes	No
Island Care	F9	1	2	73-319	Hawaii	(808) 943-1127	IPP	28.64	73.95	13.22	34.13	Both	Yes	Yes	No
Kaiser Hawaii (High)	53	1	2	73-5	Hawaii	(808) 521-0803	GPP	26.20	68.03	12.09	31.40	Both	Yes	Yes	No
Kaiser Hawaii (Stnd)	63	4	5	73-5	Hawaii	(808) 521-0803	GPP	22.21	57.06	10.25	26.33	Both	Yes	Yes	No
Puerto Rico															
Health Plus of Puerto Rico	ME	1	2	73-507	Puerto Rico	(809) 782-7900	IPP	20.77	50.56	9.58	23.33	Both	No	Yes	No
SSS Plan	89	1	2	73-16	Puerto Rico	(809) 749-4777	IPP	22.28	49.49	10.28	22.84	Both	Yes	Yes	No

ABBREVIATIONS: ECF — Extended Care Facility IPP — Individual Practice Plan
GPP — Group Practice Plan MMP — Mixed Model Plan

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